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Jon B. Christianson and Roger Feldman  
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# Evolution In The Buyers Health Care Action Group Purchasing Initiative

One of the pioneers in employer coalition-based health purchasing faces a critical test as it restructures to meet consumer demand.

*by Jon B. Christianson and Roger Feldman*

**ABSTRACT:** In 1997 the Buyers Health Care Action Group (BHCAG), a coalition of large employers in the Twin Cities, introduced a new purchasing initiative (called Choice Plus) designed to promote competition among care systems, driven by consumer choices. Our analysis suggests that consumers are playing the role, to some degree, envisioned by BHCAG. However, several issues now have caused BHCAG to dramatically restructure its approach to Choice Plus. It hopes that through this restructuring, Choice Plus will grow in the Twin Cities market and be adopted in other communities as well. The success of this new approach is by no means certain, as it faces a number of critical tests.

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THE BUYERS HEALTH CARE ACTION GROUP (BHCAG), a coalition of large employers in the Minneapolis/St. Paul area, introduced a new purchasing initiative in 1997 that has received considerable attention nationally. The stated purpose of the initiative, called Choice Plus, was to foster competition among groups of providers (not licensed health plans) on price and quality, with consumers' choices driving the process. In an earlier issue of this journal we described the design features of Choice Plus, along with BHCAG's early experience in implementing the initiative in the Twin Cities.<sup>1</sup> We noted at that time that there was little empirical evidence regarding the performance of Choice Plus but that we were in the process of examining the early impact of the initiative using consumer survey and claims data. In the first part of this paper we briefly summarize the key findings of our analysis of the survey

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*Jon Christianson is the James A. Hamilton Chair in Health Policy and Management at the Carlson School of Management, University of Minnesota. Roger Feldman is the Blue Cross Professor of Health Insurance in the Division of Health Services Research and Policy, University of Minnesota School of Public Health.*

data as they pertain to consumer decision making. (An accompanying paper by Alan Lyles and colleagues discusses trends in utilization, costs, and quality indicators constructed using claims data.)<sup>2</sup> We also describe some fairly dramatic recent developments relating to BHCAG, including a major change in BHCAG's structure, and we discuss the future of Choice Plus in the Twin Cities market and nationally.

## Consumer Response To Choice Plus

■ **Key features.** As we described in our previous paper, Choice Plus contains several features that have captured the attention of national observers. Paramount is Choice Plus's reliance on contracting with care systems rather than with health plans. Primary care providers can participate in only one care system for contracting purposes, but hospitals and specialists may affiliate with multiple systems. Care systems bid on a standardized benefit package, submitting per member per month fee-for-service expenditure targets to BHCAG.<sup>3</sup> These targets are risk-adjusted using the adjusted clinical groups (ACG) methodology to encourage competition based on price and quality, rather than risk selection. In each of its first four years Choice Plus grouped the bids into high, medium, and low cost tiers, with employees' required contributions determined in part by the cost tier in which their chosen care system was located. Family members can choose different care systems, but the family's contribution level is determined by the chosen care system in the highest cost tier. Required contribution levels vary by employer. If a care system exceeds its projected expenditure target, a "conversion factor" is lowered to reduce fees going forward. This adjustment occurs quarterly.

■ **Enrollment.** In the first year of Choice Plus, the fifteen participating care systems attracted 115,000 enrollees and dependents when offered by twenty-four large employers. Virtually all Twin Cities primary care physicians participated in a care system, and almost half of the first-year enrollment was concentrated in two large systems. During the first three years of Choice Plus the number of care systems available in the area remained relatively stable, with some reconfiguration of provider affiliations with systems. However, there was considerable movement of care systems across cost tiers. Consumers were faced with prices that varied from year to year because of changes in care system bids, in employers' contribution policies, and in the match of care systems to cost tiers.

■ **Use of quality information.** BHCAG employers intended that their purchasing initiative would create a system that would be driven by, and be responsive to, consumers' choices.<sup>4</sup> In theory, in-

formed consumers would balance the various attributes of care systems in making their choices and, on the margin, low-cost, high-quality care systems would attract more patients. BHCAG prepared and distributed comparisons of care systems in the form of the *Performance Results Book*, based on employee survey results, to help inform consumer choice. It also encouraged care systems to pursue quality improvement initiatives, provided financial awards to exemplary care systems, and, beginning in the second year, mentioned award winners in materials distributed to employees.

Because of the central role that the BHCAG initiative assigned to consumers, we undertook several analyses of consumer behavior under Choice Plus, using data collected by telephone survey of a sample of employees from nineteen BHCAG employers, with the survey conducted shortly after the second enrollment period under the new initiative (1998). The survey was designed to collect data on employees' use of information supplied by their employers and other sources when selecting a care system.<sup>5</sup>

The main findings from our analyses can be summarized as follows: (1) About 76 percent of single employees used information about care systems provided by BHCAG employers when choosing a care system. The next most commonly cited information source was prior experience with physicians and hospitals. Of those saying they used employer-provided information, 63 percent recalled seeing the report card prepared by BHCAG that compared care systems, and 59 percent of that group found the report card helpful.

(2) People with more education were more likely to use information provided by employers in choosing a care system, as were people who had lived longer in the community, holding other factors constant. Those who had seen a physician in the previous year were more likely to rely on their own experience and information from physicians in choosing a care system.

(3) According to survey respondents, the most helpful ratings in comparing care systems' performance were overall quality and service; the least helpful were detailed aspects of quality and service. Care system quality and service ratings (measured by the number of stars in the *Performance Results Book*) had a small, positive impact on choice. The quality measures did not interact with price. That is, demand for highly rated care systems was not more or less sensitive to price than was demand for systems with low ratings.

(4) The presence of a chronic condition did not predict care system choice. But consumers were less likely to choose a care system the further they resided from the nearest care system clinic and were more likely to choose a system the greater the number of primary care physicians in its network.

*“BHCAG has faced the ongoing challenge of maintaining the commitment of its participating employers.”*

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(5) Employees appeared to be sensitive to premium differences, with premium elasticities ranging from  $-1.61$  to  $-4.34$  (a 1 percent increase in the employee's out-of-pocket premium would cause enrollment in a care system to decrease by at least 1.61 percent). Older persons and those with more experience in the Twin Cities health care market were less sensitive to premium differences, but self-reported health status did not affect employees' premium sensitivity or the preference for particular care systems.

In summary, our analyses support BHCAG's expectations that providing employees with information and creating economic incentives to choose less costly provider systems makes employees sensitive to premium differences among their choices. The lack of association between health status and choice provides tentative evidence that the Choice Plus plan design, with standard benefits and risk adjustment, breaks the connection between health risk and choice, which is often seen as a drawback of choice-based health care purchasing systems. However, this needs to be examined using additional measures of health status and health conditions.

Our finding about employees' use of information from their employer runs somewhat counter to the notion that employees do not trust such information or use it in making choices.<sup>6</sup> It is also surprising that employees consider the most helpful information to be ratings of overall quality and service; conventional wisdom maintains that consumers want detailed information on other patients' experiences. It is not known whether these findings represent unique features of BHCAG's employees or whether the Choice Plus plan design actually increases the use of certain types of information.

## **BHCAG's Response To Environmental Pressures**

Despite our finding that Choice Plus has helped to create economic incentives for employees to choose less costly provider systems, and Lyles and colleagues' finding that the initiative has resulted in some degree of restraint in cost growth, the BHCAG model has faced a variety of challenges. In our previous paper we described BHCAG's early implementation challenges.<sup>7</sup> These included pressures from health plans, concerns of care systems, and the “newness” and apparent complexity of the model. BHCAG also faced the ongoing challenge of maintaining the commitment of its participating employers. Since that paper appeared, we have tracked BHCAG's expe-

rience through interviews with its staff and members and with representatives of participating care systems, as well as through review of BHCAG reports and published accounts of its activities. There have been relatively dramatic developments in all of the areas cited above, which together have caused BHCAG to rethink its structure and governance. It has responded by positioning Choice Plus as a competing health plan in the Twin Cities marketplace, in hopes that its enrollment will expand and that it will be exported to other communities as well.

■ **Retaining employers' commitment.** We observed in our previous paper that "a continual challenge for BHCAG will be to maintain its members' enthusiasm for and commitment to an approach that has very long-term objectives—restructuring the incentives and changing the behavior of a community health care system—but ample opportunity for short-term setbacks."<sup>8</sup> In this respect, the events that have received the most public attention and that ultimately galvanized change in the structure of BHCAG itself were the withdrawals of two of BHCAG's largest employers—Wells Fargo and American Express—from Choice Plus. The Wells Fargo withdrawal, which was announced 8 October 1999, was the most significant in its impact because Wells Fargo had the largest membership in Choice Plus (approximately 25,000). American Express, with 14,000 Choice Plus members, announced 7 August 2000 that it also was leaving BHCAG. Both of these employers signed contracts with HealthPartners, a large Twin Cities health plan that formerly collaborated with BHCAG to administer Choice Plus.

*Wells Fargo case.* The Wells Fargo decision resulted from a number of complications surrounding the merger of Norwest (a financial institution based in the Twin Cities) and Wells Fargo and the subsequent shift of corporate headquarters to San Francisco. It clearly illustrates the challenges that purchasing coalitions like BHCAG face in retaining members' commitment in the face of the technical and political issues that often ensue from large corporate mergers. According to our interviews, along with newspaper reports at the time, the key issue was the perceived need to bring benefits together quickly, after the merger, for employees in the new organization.<sup>9</sup> Norwest employees had already chosen care systems for 1999, but a decision was made to conduct a reenrollment in July, at which time employees would make care system choices for the next eighteen months. Health benefits budgets were set based primarily on projections of claims from 1997, which was a low-cost year. The budgeted amounts for Norwest employees proved to be too low, when new care system bids for 2000 were tabulated. In particular, the HealthPartners-owned care system moved from the low to the high cost



tier from 1999 to 2000, meaning that not enough dollars had been budgeted for the employees who had chosen HealthPartners. If it remained with BHCAG for 2000, the new company (Wells Fargo) would be forced to absorb all of this budget shortfall, given its commitments to employees. HealthPartners offered to replace Choice Plus for 2000 with one of its products for an amount that was similar to 1999 costs associated with Choice Plus. According to a Wells Fargo spokesperson, "HealthPartners presented an insured alternative that meets our needs and maintains the level of service our employees expect while doing what's best for our shareholders."<sup>10</sup> In public statements, BHCAG staff acknowledged that the loss of the Wells Fargo enrollees was a setback to their efforts to expand the presence of Choice Plus and its reform objectives in the market but noted that it would be partially offset by new firms joining Choice Plus. As of January 2000 it reported 143,000 Choice Plus members (in its 2000 annual report), down from 154,000 members reported at the time in newspaper accounts of the Wells Fargo decision.<sup>11</sup>

*American Express case.* The subsequent withdrawal of American Express further reduced enrollment in Choice Plus. As was the case with Wells Fargo, the trend rates used by American Express to project its budget for health care benefits proved too low, leading to a budget shortfall in 2000. As a result, a decision was made in corporate headquarters (not located in the Twin Cities) to seek bids from health plans for the 2001 contract year for Twin Cities employees. It may also be that firms headquartered outside of the Twin Cities place greater emphasis on having a uniform approach to employee health benefits and are less tolerant of the complexity introduced by offering the Choice Plus direct-contracting product to Twin Cities employees only.

*Impact of withdrawals.* For many BHCAG employers, Wells Fargo's decision to withdraw from Choice Plus underscored something that was already well understood: the need to establish a broader enrollment base in Choice Plus to cushion the impact of health benefits decisions made in the context of broader corporate issues. One respondent characterized the Wells Fargo withdrawal as a loud "wake-up call" because, until that time, Norwest had been perceived as a strong supporter of Choice Plus. It caused BHCAG members to rethink their relationships with care systems, as well as their ability to "grow the product" within the existing BHCAG organizational structure. Changes in both of these areas soon took place.

■ **Solidifying relationships with care systems.** Since its inception, Choice Plus has garnered varied degrees of enthusiasm among participating care systems, with small, independent systems and

systems associated with hospital networks being the most supportive.<sup>12</sup> Several events over the past two years have challenged this support.

*Enrollment growth.* First, enrollment in Choice Plus has not grown as rapidly as these systems had hoped. They view Choice Plus as an administratively expensive product, given the relatively small proportion of their patients who are Choice Plus members.<sup>13</sup> Enrollment growth is important because it creates the opportunity for care systems to spread the fixed administrative costs over more patients. The Wells Fargo and American Express withdrawals were blows to these hopes, as has been the lack of participation by state employees, a group of more than 130,000 members. The state employees' group is an associate member of BHCAG and has been exploring the possibility of joining Choice Plus or creating a parallel program. Two years ago it received approval to convert to self-insured status, to generate the claims experience necessary for care systems to bid for state employees. However, several roadblocks remain.<sup>14</sup> For instance, HealthPartners recently announced that its owned and affiliated care systems will not accept Choice Plus enrollees from employers that are offering Choice Plus for the first time, partly on the grounds that Choice Plus is a competitor and does not offer its "owned" clinics as participants in the network of competitors. This could make Choice Plus less attractive to the state.

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*New administrator.* A second event that challenged care system support was the transfer of the administrative activities associated with Choice Plus from HealthPartners to a new contractor. As we noted previously, when BHCAG announced its intention to seek proposals from a variety of entities for different administrative services, HealthPartners declined to participate in this process.<sup>15</sup> While the care systems generally applauded this change at the conceptual level, because it eliminated a potential conflict of interest arising from HealthPartners' playing both an administrative and a care system role under Choice Plus, the transfer of responsibility to a new administration proved rocky. Although the new third-party administrator (TPA) was selected more than a year in advance to facilitate a smooth transition, the care systems reported major delays in payment and poor service. They attributed this to the complexity of the BHCAG payment system, as compared with the ways in which TPAs typically pay providers, as well as misunderstandings between BHCAG and the TPA about what would be required.

*Faulty data.* At the time of the transfer to the new TPA, a third strain developed in the relationship between the care systems and BHCAG. It was discovered that the earlier claims data that BHCAG had been supplying to the care systems were incomplete, meaning



*“The Choice Plus feature that the care systems appear to value most is the ability to set their own expenditure targets.”*

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that the care systems’ performance evaluations appeared better using these data than they really were. As a result, the “conversion factors” used to calculate care systems’ reimbursements were set “too high”—that is, the care systems were paid more than they would have been paid had the data been accurate. Also, the care systems had set their bid prices for 2000 using data that underestimated use of services by care system enrollees, so their bid prices arguably were “too low” relative to what they would have been with accurate data. Clearly, until this matter was resolved, the care systems were concerned that they might be penalized financially for a mistake committed by others. Ultimately, BHCAG proposed an approach to rectifying the mistake that was satisfactory from the point of view of the care systems. The bids they had submitted for 2000 were adjusted upward retrospectively, and they were not held accountable for the previous overpayment based on faulty data.

*Pharmacy management.* Somewhat surprisingly, given these issues, support for Choice Plus among the independent care systems has grown stronger over the past two years. BHCAG is viewed by most care systems as a “good payer,” although not a major payer, and as responsive to care system concerns and suggestions for change. The care systems are particularly appreciative of the way in which BHCAG addressed the problems created by the incomplete data and by the support that BHCAG has provided in the area of pharmacy management. Beginning in 1999 BHCAG contracted with a pharmacy benefit management (PBM) company to assist care systems. The PBM provides the care systems with quarterly reports that compare pharmacy use and costs, and it offers technical support. Under the PBM, each care system can institute its own formulary, and rebates that the PBM receives from manufacturers are passed on to the care systems. The independent care systems view their relationship with the PBM as positive, but most see little that they can do to address rapidly rising drug costs, in the face of strong consumer demand buttressed by direct-to-consumer drug advertising.

*Rewarding quality.* The care systems appreciate the way in which BHCAG rewards their efforts to improve quality. In 1998 BHCAG began granting annual cash awards to care systems for exemplary quality improvement efforts; gold (\$100,000) and silver awards (\$50,000) are available, funded by BHCAG member dues. Many care system respondents praised BHCAG for this practice, noting that

the quality awards helped in securing support among network physicians for Choice Plus participation. However, the Choice Plus feature that the care systems appear to value most highly is the ability to set their own expenditure targets, which they prefer to using fee schedules or capitation rates specified by health plans with minimal negotiation.

*Expanding the care system model.* In an interesting development, a subset of the care systems (not including those associated with HealthPartners and with Allina, an integrated delivery system that also owns a health plan) have formed the Healthcare Provider Systems Council to pursue their common interests, the foremost of which is supporting the expansion of the care system model beyond Choice Plus. The council has met regularly with BHCAG for strategic planning purposes. One topic of these meetings has been the care systems' potential role as "keepers of the model." Given the events of the past two years, especially the Wells Fargo and American Express withdrawals, the council envisions an expanded role for itself, relative to BHCAG, in promoting the care system approach in the future.

■ **Restructuring BHCAG.** On 12 October 2000 BHCAG announced a major restructuring that is likely to fundamentally change the way in which Choice Plus relates to employers, health plans, and care systems. According to BHCAG staff, the restructuring was needed to remove the coalition from the day-to-day duties associated with administering Choice Plus and allow it to refocus on broader purchasing and reform goals. The restructuring also is intended to increase the opportunities available to Choice Plus for enrollment growth, in the Twin Cities and beyond.

Through a series of contractual relationships, BHCAG essentially created two separate organizations. The first, a for-profit entity, manages relations with an organization called Patient Choice Healthcare (PCH) and funds a second, nonprofit organization. PCH, a newly created entity separate from BHCAG but with leadership provided in part by a former BHCAG staff member, administers the health plan products (effective January 2001). It is expected to raise capital that will allow it to develop and market variations of Choice Plus targeted especially at small and medium-size employers. It also will work with purchasing coalitions in other communities to develop versions of Choice Plus that fit their markets.

The nonprofit part of BHCAG, renamed HealthFront, has a relatively broad mission. It is organized as a partnership of current BHCAG members and local providers, with funding from BHCAG dues and grants or contributions. HealthFront will focus on improving patient safety, health care quality, and consumerism in the com-

munity, with the help of a national advisory group and a consumer advisory group. In the opinion of BHCAG leaders, this restructuring will move BHCAG out of the “health plan administration business” and lay the groundwork for a more stable future for Choice Plus.

## Challenges And Opportunities For Choice Plus

Clearly, BHCAG’s restructuring was a gamble designed to address several pressing issues. First, it could provide a way to increase enrollment in Choice Plus, through marketing to medium-size and small employers in the Twin Cities. An increased enrollment base there would appeal to participating care systems and make Choice Plus less vulnerable to the withdrawal of individual employers. Second, the restructuring could aid in expanding the national visibility of the Choice Plus model. Because it is a private, for-profit organization, PCH can raise private investment capital to fund expansion. Many BHCAG members see Choice Plus as a viable private market reform option deserving of national attention and hope that its feasibility in other markets can be demonstrated. Third, by defining an organizational role for the council, BHCAG’s restructuring could create a stronger, more unified coalition to promote Choice Plus in the marketplace and the political arena. However, these potential outcomes from BHCAG’s restructuring are by no means assured, as the restructuring has created new challenges, along with its new opportunities.

■ **Become more competitive.** For instance, by shifting administration of Choice Plus to a separate entity, BHCAG has formally acknowledged that it has created a new health benefit option to compete with existing health plans across all segments of the employer market, and it anticipates that Twin Cities health plans will respond aggressively. Indeed, some BHCAG employers would view this as a beneficial result of the restructuring. Soon after the restructuring announcement, a Minneapolis newspaper published an editorial calling Choice Plus “an extremely valuable addition to the Twin Cities marketplace, both as a form of competition to the big plans and as an experiment in consumer choice” and urging employers to support it.<sup>16</sup> This editorial drew a rebuke from the chief marketing officer of Blue Cross Blue Shield in the Twin Cities area, who found it “frustrating” that the paper took “at face value the BHCAG claims of superior cost savings without bothering to understand whether they’re comparing apples-to-apples with other health plans” and took “a public position in favor of a particular health product that has not gained an appreciable number of new members in several years.”<sup>17</sup> Interview respondents also reported that health plan representatives are now approaching BHCAG employers at

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high levels within companies in an effort to shake corporate support for the Choice Plus model. The creation of PCH as an entity separate from BHCAG could itself diminish BHCAG employers' loyalty to and support of the Choice Plus concept in the long run. Some care system respondents believe that HealthPartners' decision to eliminate access to its care systems for new employers selecting Choice Plus is a prelude to its withdrawal from Choice Plus entirely. If this occurred, it also could reduce the attractiveness of Choice Plus for some BHCAG employers and weaken Choice Plus's growth potential in the Twin Cities.

■ **Secure sufficient operating capital.** PCH also faces the challenge of securing operating capital sufficient to sustain its expanded marketing efforts in the Twin Cities and elsewhere. The barriers to expanding to other communities are likely to be formidable. Interest in the Choice Plus approach has been expressed by some employers in Portland (OR), Denver (CO), Des Moines (IA), and Sioux Falls (SD). To the extent that these communities have local employment connected with BHCAG-participating companies in the Twin Cities, this could provide a platform for the introduction of Choice Plus. However, not all of these communities have health care delivery systems that can be configured readily around competing groups of primary care physicians, nor is there enthusiasm among all local providers for doing so. Some providers have resisted adoption of the Choice Plus payment approach, which they see as too complex and inferior to the fee-for-service arrangements of their existing health plan contracts. Thus, PCH is exploring ways to modify its payment approach to accommodate local market conditions. Also, to the extent that the Choice Plus approach reveals which care systems are more and less efficient, and consumers respond by selecting less costly systems, the care system "losers" in this process might conclude that they are better off under existing managed care contracts. As participants in managed care networks, they may be able to generate greater revenues because their higher relative costs are not a factor in consumers' choice of providers.

■ **Secure TPA contracts.** A further challenge facing PCH in expanding outside of the Twin Cities is securing contracts with TPAs to provide the necessary administrative services. The requirements of TPAs under Choice Plus in the past were substantial and differed from requirements under the products that TPAs typically administer. PCH is attempting to modify these requirements to facilitate more TPA participation.

■ **Facilitate the shift to defined contributions.** In contrast to these challenges, the increasing interest among employers in some form of "defined-contribution" strategy could support the expan-

sion of Choice Plus. A large number of different models have been identified that could facilitate the shift of employers to defined contributions for health benefits, with greater decision-making power and information to be placed in the hands of employees.<sup>18</sup> Some market analysts have characterized the Choice Plus approach as one of several alternatives that could facilitate the implementation of defined contributions without requiring that the employer totally “abandon” the employee to the individual health insurance marketplace.<sup>19</sup> Some analysts have predicted that an economic downturn might create a labor market environment more conducive to employers’ adoption of defined-contribution approaches, such as the Choice Plus model. However, Choice Plus clearly would face stiff competition from other defined-contribution models. For instance, the University of Minnesota recently decided to offer PCH to its employees but also will offer HealthPartners, Preferred One (a preferred provider organization), and Definity Health (a new defined-contribution alternative marketed nationally but located in the Twin Cities). The attractiveness of the Choice Plus model for employers considering defined-contribution approaches will depend in large part on its ability to establish and maintain a favorable track record of moderating cost increases while supporting informed consumer choice. Certainly, based on its performance to date, Choice Plus deserves to be followed closely as a private-sector alternative to the status quo in health care organization and benefit design.

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## NOTES

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2. A. Lyles et al., “Cost and Quality Trends in Direct Contracting Arrangements,” *Health Affairs* (Jan/Feb 2002): 89–102.
3. D. Knutson, “Case Study: The Minneapolis Buyers Health Care Action Group,” *Inquiry* (Summer 1998): 171–177.
4. A. Robinow, “Ensuring Health Care Quality: A Purchaser’s Perspective—A Health Care Coalition,” *Clinical Therapeutics* 19, no. 6 (1997): 1545–1554.
5. The survey was timed so that surveyed employees would remember the types of information and the decision-making process they used to select a care system in 1998. The survey was conducted with nineteen of the twenty-six BHCAG employers that had made a commitment to offer Choice Plus as their only health plan. This simplified the analysis by enabling us to focus on a subset of employees, all of whom faced the same choices. Within these nine-



teen firms, employees were sampled randomly, but the samples were stratified to increase the probability of drawing employees from the smaller companies. This approach ensured that employees from smaller firms were represented in the data. To be included in the survey, employees had to be enrolled in Choice Plus, with no eligibility for dual or substitute coverage through other public or private health insurance programs. We continued the survey until 999 employees with single coverage (91 percent response rate) and 912 families (96 percent response rate) had been interviewed. The survey contained questions on the types of information used to select a care system, employees' health status and medical care use, their experience with primary care doctors, and demographic information. We supplemented the employee survey with data obtained directly from the employers, regarding the out-of-pocket premium for each cost tier and the initiatives they used to distribute information on the cost and quality of care systems. Published or forthcoming papers using the survey data include R. Feldman, J. Christianson, and J. Schultz, "Do Consumers Use Information to Choose a Health Care Provider System?" *Milbank Memorial Quarterly* (March 2000): 47-77; K. Harris, J. Schultz, and R. Feldman, "Measuring Consumer Perceptions of Quality Differences among Competing Health Benefit Plans," *Journal of Health Economics* (forthcoming); K. Harris et al., "Consumer Perceptions of Quality Differences among Competing Health Care Systems," in *Consumer-Driven Health Care*, ed. R. Herzlinger (San Francisco: Jossey-Bass, forthcoming); J. Schultz et al., "Evaluation of Consumers' Use of Satisfaction and Quality Information on Health Care Systems," *Health Services Research* (forthcoming); and J. Schultz, "Selection of Health Care Provider Systems in a Direct Contracting Model" (Doctoral dissertation, University of Minnesota, December 2000).

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9. G. Howatt, "Wells Fargo Cuts Back Participation in Health-Care Buying Group," *Star Tribune*, 9 October 1999.
10. *Ibid.*
11. Buyers Health Care Action Group, *1999 Annual Report*, 11.
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13. J. Manning, "BHCAG Enrollees Opt for Lower Price, Higher Satisfaction," *City Business*, 6 March 1998, 3, 39.
14. *Ibid.* However, the University of Minnesota chose to break off from the state employees group and recently announced that it would offer PCH, the restructured Choice Plus arrangement (see below) to its employees, along with three other options, beginning in October 2001. See "University of Minnesota to Offer Definity Health to Its 16,000 Employees," *Star Tribune*, 12 June 2001.
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